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Letters

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MMR vaccination and autism 1998

There is no causal link between MMR vaccine and autism

EDITOR—Nichol et al considerably understate their case when they write “chance alone dictates that some cases [of autism] will appear shortly after vaccination.”¹ Such a temporal association is unremarkable, given the epidemiology of autism and MMR vaccine.

Over the time described by Wakefield et al² MMR vaccine was given to around 600 000 children each year in Britain³ and the prevalence of autistic spectrum disorders was 91/100 000.⁴

Assuming that the diagnosis of autism is evenly distributed over the second and third years of life and that the incidence over this period approximates to the current prevalence,⁵ over the eight years that the reported cases represent autism would have been diagnosed in around 364 cases in the two months after MMR vaccination (the time that the authors regard as noteworthy— $((91/100\,000) \times 600\,000) \times 8 \times (2/24) = 364$). The reported cases therefore represent a fraction of the cases of autism whose onset coincides with the administration of MMR vaccine.

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1 Nicoll A, Elliman D, Ross E. MMR vaccination and autism 1998. *BMJ* 1998;316:715-6. (7 March)

2 Wakefield AJ, Murch SH, Anthony A, Linnell J, Casson DM, Malik M, et al. Ileal-lymphoid-nodular hyperplasia, non-specific colitis, and pervasive developmental disorders in children. *Lancet* 1998;351:637-41.

3 Chen RT, DeStefano F. Vaccine adverse events: causal or coincidental? *Lancet* 1998;351:611-2.

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5 Wing L. Autistic Society Spectrum Disorders: No evidence for or against an increase in prevalence. *BMJ* 1996;312:327-8.

Those giving MMR vaccine had no input into editorial

EDITOR—The editorial by Nicoll et al about a possible link between measles, mumps, and rubella (MMR) vaccine and autism¹ is not helpful for those working in primary care who actually give the vaccine, are concerned about its potential and actual side effects, and have to deal with the effects of a scare story, as in this case. General practitioners, health visitors, and practice nurses, who all give this vaccine regularly, have had no formal input into the editorial and have not participated in the expert committee set up to review the MMR reports.

It is all very well to ask an expert committee for an opinion based on research in

secondary, and even tertiary, care. A more valuable opinion of what really happens in practice, however, would be available from those who actually have the day to day experience of this vaccine in use, and that includes parents.

Public concern about the safety of MMR vaccine has not only been raised by the study of Wakefield et al.² In 1992 and 1993 one of the commonly used MMR vaccines was withdrawn because of recurrent reports of adverse effects. I remember seeing three cases of encephalitis after MMR vaccinations in my own baby clinic at that time, although thankfully these resolved.

Concerns after a television advertisement for the MR booster campaign in 1994 and 1995 left parents wondering whether the advertisement was meant to scare them into having the vaccination done. This may explain in part the media response to Wakefield's study.²

What we would have needed from the editorial were some straightforward figures to help parents understand why their child should have this vaccine. An unvaccinated child is 20 times more likely to have a serious complication from measles, mumps, or rubella than he or she would be after MMR vaccination.

Finally, I assume that the last paragraph of the editorial contains an error: “While vaccine can be guaranteed to be without any risk ...”¹ No vaccine or drug can ever be guaranteed to be without any risk.

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2 Wakefield AJ, Murch SH, Anthony A, Linnell J, Casson DM, Malik M, et al. Ileal-lymphoid-nodular hyperplasia, non-specific colitis and pervasive development disorder in children. *Lancet* 1998;351:637-41.

Medical practitioners need to give more than reassurance

EDITOR—Can I present a challenge to Nicoll et al?¹ As a parent of young children I have become aware of a website—“The informed parent” (<http://www.unc.edu/~aphillip/WNW/vaccine/dvm.txt>)—that is having a profound influence on many of my non-medical friends who have small children. Although the website is written by a non-physician, it is written in the style of a medical journal, which lends it more authority than it may merit. This website argues that vaccination is dangerous and unnecessary.

The issue is about risk and the perception of risk. There may also be a perception of secrecy about problems with vaccines in the United Kingdom, which is why this website is now so influential. In a consumer led NHS it is no longer sufficient for general practitioners and practice nurses to give simple reassurance.

The challenge is to produce information for parents that is accessible (including on the internet) and balanced, and that addresses the specific concerns that websites such as “The informed parent” engender. This is a particular example of patient empowerment, and the medical profession needs to do more than just convince itself of the safety of vaccination.

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The health of Gypsies

Problem of caring for travellers is British, not just European

EDITOR—The editorial by McKee¹ on Gypsies, or Romas, was an interesting factual account of their origins as well as of the disadvantages and oppression they face as a minority group in continental Europe. Yet it is remarkable in that there is no mention of the disadvantages and oppression endured by the same minority community in the United Kingdom—from the Romas of folklore in the south of England to the tinkers of Scotland and to the New Age wanderers who seem to seek the romantic image without the responsibilities. Now they travel in trucks towing large caravans; when parked they are usually seen in lay-bys or on waste ground with lots of dogs, children, and rubbish.

In these unofficial caravan sites they live in the squalor and type of conditions prevailing in this country a couple of centuries ago—no clean or adequate water supply, no sewage disposal system, no rubbish collection, and certainly totally inadequate education, immunisation, and medical attention. The reaction is often to “get rid of them,” preferably by moving them on to some rundown housing estate in the next town but one. Local authorities have a duty to provide proper sites for travelling people, although this is too often frustrated by the “not in my back yard” (“nimby”) attitude and an inability of local authorities to attempt to work with the Gypsy culture by cooperating with their lifestyle.

It is easy to be disapproving about the unwelcome refugees in and around Dover. As far as our own travellers are concerned, it is a sad reflection on our society, and perhaps on the *BMJ*, that we behave as if nothing needs to be done in this country although it seems to be agreed that much needs to be done across the channel.

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Governments and Roma communities must help to improve outlook for Gypsies

EDITOR—In his editorial on the health of Gypsies—an important minority in central and eastern Europe—McKee states that “health policymakers and researchers have paid little attention to the health needs of Roma people.”¹ This is not true. The communist regime in the former Czechoslovakia spent considerable sums to improve the economic, health, and housing situation of the “proletarian” Roma population. Infant mortality of Gypsies decreased considerably and the number of Gypsies living in Slovakia more than trebled from the end of the second world war to 1990.² Health care as well as the educational system in Slovakia was free and equally available to all Slovaks, Hungarians, and Gypsies. After the change from a socialist economy to a free market economy, unemployment among the Roma minority rapidly increased. The main reason was not racism but the low educational level and low working activity of Gypsies.

In 1996 we performed sociological research in various parts of Slovakia by a Gallup method. The table summarises some data from a representative sample of 1016 men aged 25-55 living in the multiethnic district of Levice on the border with Hungary (about 65% Slovaks, 30% Hungarians, and 5% Gypsies). The data are similar for both Slovaks and Hungarians and very different for Roma men: the Roma minority

had an extremely high consumption of cigarettes, beer, and spirits; low consumption of milk, fruit, and vegetables; a lower cultural level; a higher prevalence of sleep disorders; a lower health status; and a high birth rate.

Although Roma people continue to exist on the margins of society and their life expectancy is low, the number of Gypsies in Slovakia increased by 1-2 % a year between 1991 and 1996.³ The reason for the high reproductive activity in Roma people is an economic one—regular financial support from state sources for each child. If this trend does not change, the Roma minority in 2010 will form about a fifth of the young and middle aged population in Slovakia. Most Gypsies will have only elementary education and will be unemployed, chronically ill, and dependent on financial support from the state. A huge increase in crime could be expected, and the final result could well be an increase in racist attacks, ethnic conflicts, and an exodus of Gypsies to the “rich” West.

Prevention of this pessimistic scenario is not in the hands of health policymakers and medical researchers. Extensive educational programmes, control of the birth rate, new economic chances, and a change of lifestyle are the best that east European governments and Roma communities themselves could do for the health needs and the future of Roma people.

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2 Srb V. Roma people in Czechoslovakia according to census 1991. *Demografie* 1993;35:282-9.

3 Statistical Office of the Slovak Republic. *Statistical yearbook of the Slovak Republic 1996*. Bratislava: SOSR, 1996.

Citalopram is safe

EDITOR—Power comments on my assertion that all selective serotonin reuptake inhibitors seem safe in overdose,¹ citing six published cases of suicide in which citalopram was strongly suggested to have caused

death. Although no drug is absolutely safe in overdose, the relative safety of the selective serotonin reuptake inhibitors compared with tricyclic antidepressants in this regard has been shown by many years of clinical experience.²

Citalopram is the most widely prescribed antidepressant in Sweden, and the Swedish Poisons Information Centre at the Karolinska Hospital has reported data on 104 cases of “pure” citalopram overdose treated in Swedish hospitals in 1995-6.³ Nausea, dizziness, and drowsiness were seen in patients who had ingested up to 30 times the usual therapeutic dose of 20 mg. In cases where up to 95 times the usual therapeutic dose was taken seizures and electrocardiographic abnormalities were reported, but there were no deaths or serious arrhythmias. The largest overdose in this series was equivalent to over 9 months’ treatment at 20 mg daily, showing considerable determination on the part of the patient, who made a full recovery.

The authors of the study concluded that most citalopram overdoses have an uneventful course.³ An overdose of 4000 mg of apparently “pure” citalopram resulting in death⁴ was of similar size to a reported fatal overdose of fluoxetine taken alone.⁵ Power reasonably concludes that the true safety of a drug in overdose cannot fully be determined until the drug has seen extensive clinical use. Citalopram has been available in some countries since 1989, and it is estimated to have been used in routine clinical practice in almost 8 million patients. Thus there seems to me no reason to question the safety profile of citalopram any more than that of other selective serotonin uptake inhibitors.

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1 Power A. Drug treatment of depression. *BMJ* 1998;316: 307-8. (24 January.)

2 Glassman AH. Citalopram toxicity. *Lancet* 1997;350:318.

3 Persson M, Persson H, Sjöberg G. Citalopram toxicity. *Lancet* 1997;350:518-9.

4 Oström M, Eriksson A, Thorson J, Spigser O. Fatal overdose with citalopram. *Lancet* 1996;348:339-40.

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Differences between Gypsies, Slovaks, and Hungarians living in Slovakia (district of Levice), 1996. Figures are number (percentages) of positive answers

	Slovaks	Hungarians	Gypsies
No of respondents	655	314	47
Age (SD) (years)	37.9 (8.5)	38.4 (8.3)	38.0 (8.4)
Responses to questions asked			
Daily or almost daily consumption of:			
Milk and milk products	286 (43.6)	140 (44.6)	12 (25.5)
Fruit	285 (43.5)	151 (48.0)	9 (19.2)
Vegetables	280 (42.8)	171 (54.5)	15 (31.9)
Beer	189 (28.8)	75 (23.9)	23 (49.0)
Spirits	67 (10.2)	30 (9.6)	11 (23.4)
Often in conflicts with other people	87 (13.3)	44 (14.0)	16 (34.0)
Agreed with statement “I have no chance to influence my future”	70 (10.7)	34 (10.8)	13 (27.7)
Poor health status	51 (7.8)	22 (7.0)	10 (21.3)
Sleep disorders	53 (8.1)	30 (9.6)	8 (17.0)
Almost no reading of newspapers	178 (27.1)	55 (17.5)	23 (48.9)
No book read during past year	262 (40.0)	146 (46.5)	35 (74.5)
Smoker	329 (50.2)	167 (53.2)	37 (78.7)
Father of more than two children	91 (13.9)	43 (13.7)	24 (51.1)

Removing intravascular lines at 72 hours allows need for antibiotics to be reassessed

EDITOR—Randolph et al’s meta-analysis suggests that continuous infusions of low dose heparin prolong the patency of arterial and venous peripheral catheters.¹ This is encouraging for both patients with needle phobia and junior doctors. The authors do not, however, emphasise the risks of invasive vascular devices, particularly the infective risks.

Although some studies disagree, it is widely accepted that rates of phlebitis and infection (both local and systemic) associated with intravascular lines are related to the duration of insertion.² The American Hospital Infection Control Practices Advisory Committee strongly recommends

replacing peripheral venous catheters in adults every 48-72 hours.

The problem of hospital acquired infection related to intravascular lines should not be underestimated. A recent survey by the Public Health Laboratory Service found that invasive devices constituted by far the most important risk factor for hospital acquired infection.³ From our own unpublished figures we found that 37% of cases of hospital acquired bacteraemia over two months were related to an intravascular line. Of these, 14% were associated with peripheral venous catheters; these catheters were probably underrepresented, because peripheral line tips are submitted for microbiological analysis infrequently.

In addition, the increasing rates of colonisation of hospital inpatients with resistant organisms, particularly methicillin resistant *Staphylococcus aureus*, are producing a concomitant increase in resistant bacteraemia related to lines.⁴ Analysis of bacteraemias within our trust over 17 months showed that 31% of all bacteraemias due to *S aureus* were resistant to methicillin.

Showing that the use of continuous infusions helps to decrease phlebitis is encouraging, and the decreased frequency of handling of the catheter hub site would reduce the risk of contamination—now a recognised factor in the pathogenesis of infection associated with intravascular devices.⁵ However, we would strongly advise against allowing the lack of visible inflammation to lead to continued use of peripheral intravenous lines. A policy of removing lines at 72 hours would allow consideration of the need for continued antibiotics or for switching to oral treatment with the attendant cost savings, patient comfort, and possible earlier discharge.

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Exceptionalism in HIV

Challenge for Africa too

EDITOR—The 24 January issue on antenatal HIV testing emphasised the need to promote routine voluntary HIV counselling and testing to maximise the opportunity for interventions in those found to be infected. More than 20 million of the 30 million people estimated to be infected with HIV at the end of 1997 live in sub-Saharan Africa, where some spend less than \$15 (£9) per capita on health

each year and over 90% of those infected are unaware of their infection. The opportunities for the medical interventions discussed are therefore limited.

Nevertheless, although individual benefits may be small, the potential benefits for society are huge. HIV/AIDS "exceptionalism" in parts of Africa has led to an environment of stigma and denial, with the tacit support of policy makers and healthcare staff. HIV is rarely entered in African death certificates, yet treatment decisions are made on the assumption that a patient is infected. Half of those counselling others to consider HIV testing choose not to be tested themselves.¹ Fewer than half those tested feel able to tell their sexual partner that they have been tested, whatever the result.² Many people assume that they are infected and that testing would merely increase despondency. Only 7% of couples invited for counselling and testing in Lusaka decided to have a test.³

Normalisation, as defined by De Cock and Johnson, would be an important step in improving the environment for preventing HIV transmission.⁴ However, to maximise the impact of HIV testing on prevention it needs to be promoted earlier. Women attending antenatal clinics provide an opportunity for screening. However, if anti-retroviral drugs are not available and if strong financial, cultural, and public health considerations make avoiding breast feeding difficult, the distress and anxiety caused by discovery of a woman's HIV seropositivity when she is already pregnant may outweigh the benefits. Promotion of voluntary HIV testing for young people before they are pregnant or sick would offer greater chances of preventing transmission.

Among clients of TASO, the largest AIDS support organisation in Africa, the most commonly cited advantage of being tested was access to the centre's basic medical service.⁵ In Lusaka, the most common reason for declining a test was that no medical intervention was available.³ Prophylaxis against tuberculosis is beneficial to HIV positive people even in areas of high tuberculosis transmission. Thus, relatively small and low cost improvements to the care and support offered to HIV positive people could enhance demand for testing and help to bring HIV back to normality in Africa too.

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⁵ Tanzanian AIDS Support Organisation, World Health Organisation. *TASO Uganda the inside story*. Geneva: WHO, 1995. (WHO/GPA/HCS/95.1.)

Past experience has been ignored

EDITOR—De Cock and Johnson propose the "normalisation" of current HIV testing practice, which they describe as "exceptionalism."¹ This description of the past flagrant disregard of epidemiological and ethical principle sounds impressive, and the authors go on to state that this policy of exceptionalism had the support of, among other groups named, "physicians."

The fact is that many doctors disagreed with BMA resolutions on HIV testing policies, which defied common logic and morality. Clear issues of disease management were obfuscated by unethical and irrelevant arguments about citizens' legal, civil, and personal rights. Rational thinking fell prey to vocal lay pressure groups. Emotive expressions such as horrible disease, fatal illness, social stigma, employment threat, insurance risk, informed consent, and other newly coined phrases became grounds for advising patients not to have HIV tests in case the result was positive. Legal "experts" pronounced on hypothetical situations never contested in court. Doctors seemed frightened into forgetting that less than half a century ago syphilis, gonorrhoea, tuberculosis, and smallpox were horrible, unpleasant, and (except gonorrhoea) commonly fatal diseases without known effective drug treatment.

The tried principles of our predecessors were ignored, and the authors rightly mention that the legal matter of responsibility for all this may now become a matter of negligence. This country has untraceable women citizens who have tested HIV positive. There are counselled people who have refused tests and may be HIV positive. Spouses, partners, and others are at risk, and babies, lacking effective drug protection, will be born HIV positive. The public will soon perceive the immorality of using anonymous antenatal blood samples for obtaining central government HIV statistics. Changes must be immediate.

HIV testing should become routine for antenatal clinics. Counselling should be reserved for HIV positive patients. Similar testing should become routine at all sexually transmitted disease clinics.

This country is fortunate that HIV has proved less infectious than at first was feared. Britain could have had a major public health problem. Before marrying in America many years ago, I required a certificate of negative syphilis serology. My wife, during pregnancies, was neither asked nor counselled before she was tested for syphilis in Britain. Ian Grant's prophetic letter in 1988² should be reprinted.

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CAGE questionnaire allows doctors to avoid focusing on specifics of drinking

EDITOR—Perhaps I should be flattered that my CAGE questionnaire is so popular that the *BMJ* printed it twice in 1997—though without proper attribution on both occasions. One of the articles by Ashworth and Gerada in the ABC of Mental Health uses the CAGE questionnaire as if it had just appeared out of nowhere rather than being the result of clinical studies and efforts to develop a brief and easily remembered series of questions.¹ The citation should have been given.²

Ashworth and Gerada should read a paper by Steinweg and Worth, who write: "Our study demonstrates the negative impact of asking patients to discuss the specifics of their drinking. Not only can it make for an uncomfortable interview, it is diagnostically self defeating. The CAGE questions offer the physician powerful tools to avoid focusing on the specifics of drinking. However, important keys to the CAGE are open ended introductions and resisting the urge to ask the patient to quantitate consumption."³ Ashworth and Gerada do the opposite in their recommendations. After a focus on amount, time, and pattern of consumption they say: "Specific questioning should continue with the CAGE questionnaire." I think that study of Steinweg and Worth's paper will persuade them to change their recommendations.

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Audit Commission tackles anaesthetic services

Anaesthesia should remain physician based service.

EDITOR—We read with interest the articles^{1 2} that you recently published in response to the Audit Commission's *Anaesthesia under Examination*,³ which revisits the topic of nurse anaesthetists. We trained as anaesthetists in the United Kingdom but now work in the United States.

Nurse anaesthetists in the United States always work under the direction of a physician and, despite our initial reservations, we have all been pleasantly surprised by the experience of working with this highly qualified group of professionals. Minimal requirements for entry to the training programmes of two to three years are a nursing or basic science college degree and one year's experience in critical care nursing. Fear of unemployment in recent years has produced a sharp fall in applications to anaesthesia residency programmes.⁴ Most

programmes have downsized, and a few have closed altogether. Rather than appoint more consultants, many hospitals have recruited nurse anaesthetists to meet their commitments—an expensive solution as salaries for nurse anaesthetists, which average £50 000, are more than twice those of residents.

The US Health Care Financing Administration recently announced a proposal to eliminate the federal requirement for supervision of nurse anaesthetists by physicians. This move is being supported by the American Association of Nurse Anesthetists. If approved, the proposal could allow independent practice in some states. The American Society of Anesthesiologists has urged its members to respond "vigorously" to the proposal.

Why can't nurses be a part of anaesthesia in Britain? The simple answer is: "It's too late." Assuming that a pool of sufficiently trained and motivated nurses who are willing to take up the challenge actually exists, will there be any jobs for them by the time they emerge from training? Who should train and accredit nurse anaesthetists—and could recruitment to nurse anaesthesia deprive other areas of its skilled practitioners? Unlike his or her American counterpart, the average British trainee in anaesthesia often works with little or no supervision. British trainees are paid less than their regular rates of pay for contractual overtime. We believe that it is unlikely that nurses would tolerate being used to replace trainees in anaesthesia under the same conditions. Employing nurses as replacements for consultants, which could conceivably happen in the United States, would threaten the fundamental involvement of the practice of medicine in anaesthesia.

The practice of anaesthesia is much more than the administration of anaesthetics and for this reason anaesthesia should remain, at least in the United Kingdom, a physician based service.

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1 Smith A. Audit Commission tackles anaesthetic services. *BMJ* 1998;316:3-4. (3 January)

2 Wise J. NHS urged to appoint nurse anaesthetists. *BMJ* 1998;316:10. (3 January)

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Non-physician anaesthetists may free up consultants to concentrate on patients requiring special attention

EDITOR—Smith's editorial gives an overview of the Audit Commission's report on anaesthetic services.¹ Inevitably, however, headline reporting in both the lay and the medical press concentrated on the report's

recommendation to consider the introduction of non-physician anaesthetists into British practice. Smith points out the firm opposition of the Association of Anaesthetists to this—a result of concerns over the safety of patients, legal ambiguities, and cost.² Rather than being seen as a threat, however, the report should act as an impetus for anaesthesia in the United Kingdom to reconsider this entrenched, "closed shop" attitude.

Much routine minor and intermediate surgery performed on fit patients does not require the presence of a fully trained consultant anaesthetist for the entire duration. The training guidelines of the Royal College of Anaesthetists³ suggest that, after an introductory module of 12 weeks, medically qualified trainees may have "level 2" supervision for some straightforward cases. This is defined as: "Trainer present in the operating theatre suite ... available to assist or advise."

Historically, much routine work has been done by trainee anaesthetists under the (sometimes fairly distant) supervision of consultants. As a result of the Calman reforms and limits on working hours this service contribution from trainee doctors is being reduced drastically. At the same time, the demands on anaesthesia services are growing constantly. The answer to this problem should not be simply to seek ever increasing numbers of consultant anaesthetists to perform undemanding work, but rather to encourage the development of non-physician anaesthesia practitioners, trained and supervised by medically qualified anaesthetists. Surely, a nurse or other medical professional who would undertake two or three years' training in anaesthesia could provide care at least equivalent to that of a trainee doctor.

This would provide consultant anaesthetists working both in and out of operating theatres time to concentrate on those patients who require the benefit of their medical training and extended specialist experience.

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1 Smith A. Audit Commission tackles anaesthetic services. *BMJ* 1998;316:3-4. (3 January)

2 Association of Anaesthetists. *Anaesthesia in Great Britain and Ireland: a physician only service*. London: AAGBI, 1994.

3 The Royal College of Anaesthetists. *Specialist Training in Anaesthesia, Supervision and Assessment*. London: RCA, 1994.

Quoted paper did not say that participation of nurses makes adverse outcomes more common

EDITOR—In his editorial¹ Smith quoted a paper that I cowrote² to support his argument that adverse outcomes in anaesthesia are more common when anaesthetics are given by nurse anaesthetists.

Our article did not mention anything of this sort. We had conducted a retrospective analysis of all reports that an anaesthetic department of a university hospital made to the faults, accidents and near accidents committee of that hospital over 10 years.

We did not analyse the data on the basis of who gave the anaesthetics. This was irrelevant for our study since it is the practice in all university hospitals in the Netherlands that anaesthesia is given by a team consisting of an anaesthesia trainee and an anaesthetic nurse under the direct supervision of a qualified specialist anaesthetist. It is unfortunate that our study has been misquoted in support of the argument that nurse anaesthetists are not as safe as medical anaesthesiologists.

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Investment is required to increase number of consultant anaesthetists

EDITOR—I am used to seeing misrepresentative headlines in the tabloid press but am surprised to see one in the *BMJ*.¹ The Audit Commission's wide ranging report *Anaesthesia under Examination* makes no mention of urging the NHS to appoint nurse anaesthetists as the title of Wise's article suggests.²

The report does recognise that one obvious way to reduce the demand for more doctors substantially is to allow non-medical staff to administer anaesthesia. This cannot be argued with. The actual recommendations, however, are much more tentative and suggest that hospitals such as small district general hospitals, with few trainees or perhaps none at all, might benefit from a trial of using non-physician anaesthetists (or physicians' assistants, as they are called in some parts of the United States) to help the lone consultant. This would involve an extension of the role of the anaesthetic nurse or operating department assistant to a more active role in the maintenance of anaesthesia. In certain circumstances this might lead to the consultant supervising two operating theatres at one time, with suitable staff and a suitable case mix.

This system might well be acceptable to some consultants without any trainees, who must be willing to take on the additional responsibility and should be paid appropriately to do so. But it is patently not the traditional role of the nurse anaesthetist in the United States, where many small hospitals are virtually autonomous and only nominally under the charge of a surgeon, let alone an anaesthetist. I suspect that few patients in the United Kingdom would be willing to accept this arrangement.

A survey of staffing in anaesthesia showed that the United Kingdom (and the Republic of Ireland) has by far the lowest number of consultants per 100 000 population (4.6 in the UK v 10.8 in 17 European countries).³ Despite the much higher number of consultants (with fewer trainees) in the rest of Europe, however, greater use is made there of anaesthesia nurses (15.5/100 000 in

Germany and about 23/100 000 in Norway and Sweden). So no cost savings are made.

Thus international evidence shows clearly that as (or if) the number of trainees is reduced a massive investment is required in consultant anaesthetists to bring the United Kingdom into line with the rest of Europe. Only when this has occurred is a trial with non-physician anaesthetists warranted.

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Experience is paramount for successful management of disease

EDITOR—Earlier this week the medical firm on which I am registrar was on general medical intake. After a quiet day things began to get busy around 11 pm. Two patients with suspected oesophageal varices and haematemesis arrived almost simultaneously. Both had signs of cardiovascular compromise. Around midnight a woman with an anterior myocardial infarct was given thrombolysis. At 2 30 am the same patient developed transient complete heart block and pulmonary oedema, then ventricular tachycardia followed by atrial fibrillation. Too short of breath to lie flat for transvenous pacing, she was successfully managed with an external pacing device, followed by intravenous amiodarone and carefully titrated doses of intravenous nitrates.

Our firm comprises one house officer, two senior house officers, and a registrar, and at the time of writing it had a third senior house officer funded from the contingency money that we received from the government to deal with a potential winter crisis. To comply with the new deal for junior doctors' hours the house officer goes to bed at midnight and the senior house officers split the night, only one being up at a time. Accordingly I, as the duty registrar, managed all of the ill patients described above. The duty senior house officer was clerking patients who had taken overdoses or had other less acute problems for most of the night and was therefore unable to be present with me. As a fairly experienced registrar I have managed similar cases countless times before. I am experienced at staying awake and managing patients "hands on" when needed, as was no doubt the case here.

What is disturbing is that not one of the four doctors junior to me on the firm learnt anything about the management of patients with acute serious illness that night. In three years from now I might be a consultant. Those doctors, deprived of experience by the new deal, may be medical registrars. My own mother will be approaching the same age as the patient with the infarct. From the time of

Hippocrates experience has been recognised as paramount for the successful management of disease. Are our mothers and fathers to be managed by inexperienced doctors?

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Urgency and priority models

Model has limited practical application

EDITOR—The recent interest in priority scoring for surgical operations is to be commended. The paper by the Northern Ireland Clinical Resource Efficiency Support Team highlights the differences between "urgency" and "priority" and how demographic and lifestyle related details may influence the timing of coronary artery bypass surgery.¹ Unfortunately this model has limited practical application.

Firstly, although the opinion of the referring doctor is important, the ultimate responsibility for prioritising the waiting list lies with the cardiac surgeons, who represented only a minority of the judges (4 out of 33). Furthermore, the study does not take into account how cardiac surgeons organise their waiting lists. Some run their list individually and some operate a joint waiting list; most would separate the list into emergency, urgent, and routine cases, but few would adopt a more sophisticated priority system within each group. This is not to say such an approach would be wrong, but it would imply a constant reshuffling of patients as the list grew and would make it impossible to give patients a reasonable estimate of their wait.

Secondly, inspection of the angiogram is an integral part of patient assessment, but this was denied to the judges in this study. Simply recording the number of severely diseased vessels fails to take into account the importance of the anatomical location of the stenoses, the dominance of the coronary vessels, and their relative size. A stenosis of the proximal left anterior descending artery in association with a tight proximal circumflex stenosis would be assigned more urgency and priority than perhaps a stenosis of the distal left anterior descending artery in combination with disease in the posterior descending artery—yet both are examples of two vessel disease. This point is particularly identified in a study from New Zealand.²

Finally, the success of interventional cardiology creates an increasing number of grey areas. The option to treat surgically or by endovascular intervention may be biased by the relative length of the waiting list for each technique and by the patient's own wishes, as much as by the clinical need for intervention.

Although the model presented allows those deciding about waiting lists some insights into how others view the surgical treatment of coronary artery disease, the decisions made were based on insufficient clinical data and may not reflect current practice. Unfortunately, this model also fails

to recognise the key role of the cardiac surgeon as the "gate keeper" of the waiting list.

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- 1 Kee F, McDonald P, Kirwan JR, Patterson CC, Love AHG. Urgency and priority for cardiac surgery: a clinical judgment analysis. *BMJ* 1998;316:925-9. (21 March.)
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Distinction between urgency and priority helps no one

EDITOR—Kee et al distinguish between urgency and priority in patients waiting for coronary artery bypass surgery.¹

In practice such a distinction is so fine as to be pointless; the most urgent patients receive the highest priority. It is not necessary to convene workshops and invoke paper patients to determine urgency. The amount of research on coronary artery bypass surgery allows the survival benefits over medical treatment to be defined precisely.²

For example, patients with three vessel coronary artery disease and angina of class III or IV have a one year survival of 94% after coronary artery bypass surgery and of 85% if treated medically.² If these patients are kept on a waiting list for one year twice as many will die as would if they underwent immediate surgery. This calculation can be made for any patient in whom the bypass operation affords prognostic benefit, which allows prioritisation in a quantifiable way.

We have analysed a random sample of 67 patients from one health district who underwent coronary artery bypass grafting between 1 April 1996 and 31 December 1997. The reason for the operation was to improve prognosis, regardless of the severity of symptoms (class 1), or to improve symptoms alone, as defined by the American College of Cardiology and American Heart Association (class 2).² In 56 patients the bypass operation conferred a survival advantage. These patients had a shorter wait than those operated on for symptoms alone (table). Those with the most threatening coronary artery disease and the worst symptoms had the shortest wait (table). Nevertheless the 25 patients with three vessel disease and class III or IV angina still waited a median of 81 days (interquartile range 38 to 169).

We believe that these data show that the priority given to these patients is appropriate, given what is known of the clinical course of coronary artery disease. We also believe that some of these waiting times are unacceptable. No amount of "clinical judgment analysis" can alter this. Waiting lists can

be reduced only by increasing the number of operations or denying surgery to certain patients who currently benefit. Muddying the waters with academic distinctions between urgency and priority and the effect that "lifestyle characteristics" have on this helps no one—our patients least of all.

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- 1 Kee F, McDonald P, Kirwan JR, Patterson CC, Love AHG. Urgency and priority for cardiac surgery: a clinical judgment analysis. *BMJ* 1998;316:925-9. (21 March.)
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Clinical and economic arguments favour extension to upper age limit for breast screening

EDITOR—In an editorial Sutton argues that the upper age limit of 64 for breast screening is illogical, and he ascribes it to ageism.¹ This may be true, but there is no economic rationale for limiting routine screening to women below the age of 65. Indeed, the most cost effective age in terms of cost per life year saved by breast screening is 70.² We have recently set out the economic arguments for extending breast screening to women aged over 64³; some of them bear repeating. Firstly, there is the issue of poor compliance with screening. The level of compliance with any screening programme is an economic issue only if those who do not comply are at higher risk than those who do, which for breast screening does not seem to be the case.⁴ Secondly, poor compliance is sometimes wrongly associated with non-attendance. Non-attendance wastes screening resources, but if the national breast screening service were to use an efficient appointment method that required women to confirm their intention to attend then non-attendance could be reduced to negligible levels.⁵ Thus absolute levels of compliance for breast screening are largely irrelevant for cost effective screening.⁴ For instance, if compliance of 90% produces a fall in deaths from breast cancer of 30% then a compliance level of 45% that reduces deaths by 15% at half the cost is still cost effective.⁴ The reason that breast screening has not been extended to older women is probably confusion of screening objectives

rather than ageism. Compliance with screening has been implicitly and explicitly set as a key objective when really the ultimate objective of screening should be a reduction in mortality and morbidity from the disease.⁴ One reason why screening of older women has not been adopted, despite the overwhelming clinical and economic arguments for it, is resource limitation. This, however, can be addressed by simply abandoning screening for women aged 50-53 and redirecting the resources to women aged 66-69. Such a policy would increase the numbers of life years saved by 5% at no extra cost.³

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Gamete donors for IVF should relinquish right of ownership to resulting embryos

EDITOR—The Human Fertilisation and Embryology Act states that gamete donors have rights over the destiny of their gametes and any embryos resulting from their use.¹ Donors are volunteers, who are given a full explanation of the use of their gametes for clinical or research purposes. After counselling, donors proceed to donation only if they are in full agreement about the use of their gametes, which extends to deciding the fate of any resulting embryos from their donation.

The length of time that embryos can be stored by cryopreservation has recently been extended from five to 10 years, provided that the natural parents of the frozen embryos consent to this. It is essential that both parents agree about the length of cryopreservation. In cases in which one of the natural parents is a donor, his or her agreement must be obtained before the fate of the frozen embryos is decided, whatever the other natural parent may wish.

We recently encountered a difficult situation. A couple receiving in vitro fertilisation with donated sperm had eight

Median waiting times (in days) for coronary artery bypass surgery (with interquartile ranges)

Treatment category	Overall	Angina*			3 vessel disease	Proximal LAD disease	Left main stem stenosis
		class II	class III	class IV			
Class 1 (n=56)†	84 (41 to 194)	190 (116 to 297)	104 (50 to 219)	42 (15 to 72)F	119 (50 to 243)	71 (39 to 167)	61 (40 to 92)
Class 2 (n=11)‡	232 (130 to 247)	236 (232 to 239)§	130 (119 to 141)¶	221* (195 to 246)¶	NA	NA	NA

LAD=left anterior descending coronary artery. NA=not applicable. *According to classification of Canadian Cardiovascular Society. †Prognostic benefit with or without symptomatic benefit. ‡Symptomatic benefit only. §Three patients. ¶Four patients.

embryos frozen at the end of treatment, which were still frozen at the end of the initial five year storage period. The donor could not be contacted to provide consent to further storage. Although the female partner was the natural mother of the frozen embryos, because the sperm donor could not be contacted and the patients did not wish to put the matter before the law an extension to embryo storage could not be allowed and the embryos were destroyed.

To prevent this situation arising again, we believe that after treatment the responsibility for donated gametes should be accepted by the patient or couple to whom they are donated. The fate of embryos resulting from gamete donation should be decided solely by the patient or couple, after counselling.

A change in the Human Fertilisation and Embryology Act is necessary to reflect these views and to strengthen the rights of patients as to the fate of donated gametes and resulting embryos. Gamete donors consenting to the use of their gametes for clinical purposes should relinquish the right of ownership for any resulting embryos to the couple for whom the embryos are intended. This will effectively give the patients sole authority over the fate of frozen embryos.

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1 *Human Fertilisation and Embryology Act (1990) schedule 3.* London: HMSO, 1990.

Water fluoridation is safe and effective

EDITOR—I was not surprised that Gibson and Gibson¹ had to rely on a paper published 50 years ago to support their claim that water fluoridation was not effective in preventing tooth decay and that it was harmful to health. However, the paper they cited² did not mention either a delay in tooth eruption or an increase in infant mortality, both of which they claim have been shown to be associated with fluoridation.

Gibson and Gibson are correct in identifying some areas where water is not fluoridated as areas with good dental health. Tooth decay is, like many other diseases, associated with social deprivation. In Britain there is also a gradient of dental health that runs from north to south. Children in middle class areas in the south east would therefore be expected to have lower rates of dental caries.

In 1995-96, eight of the 11 health authorities with the lowest prevalence of tooth decay among 5 year olds received fluoridated water, while nationally just over 10% of the country has fluoridated water. At the other end of the league table no district in which more than 25% of the population

drink fluoridated water has even half as much dental decay as the worst area that does not drink fluoridated water.

In their paper on fluoridation and social deprivation Jones et al³ caution against basing claims on selective quotation from the literature. Selective misquotation and misinterpretation need even more vigorous rebuttal. The scientific evidence is clear. Fluoridation is both effective and safe. Public opinion surveys confirm that the overwhelming majority of the population are in favour of water fluoridation.⁴ It is time that the UK government took action to prevent the privatised water companies from having a veto over public health policies that have been set by health authorities as a result of extensive consultation.

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1 Gibson SLM, Gibson RG. Water fluoridation and tooth decay in 5 year olds: authors did not compare like with like. *BMJ* 1998;316:231. (17 January.)

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3 Jones CM, Taylor GO, Whittle JG, Evans D, Trotter DP. Water fluoridation, tooth decay in five year olds, and social deprivation measured by the Jarman score: analysis of data from British dental surveys. *BMJ* 1997;315:514-7. (30 August.)

4 British Fluoridation Society. *Briefing on public attitudes towards fluoridation*. Liverpool: BFS, 1992.

Filters inserted into the vena cava may be useful for some indications

EDITOR—Minerva suggests that a study published in the *New England Journal of Medicine* on the insertion of a filter into the vena cava to prevent pulmonary embolism casts doubt on the value of this treatment.¹ In this study patients with proximal deep vein thrombosis, deemed to be at high risk of pulmonary embolism, were randomly assigned either to have a filter inserted or to treatment with low molecular weight heparin. Most interventional radiologists in the United Kingdom would not recognise this diagnosis as a clear indication for insertion of a filter. The indications commonly treated in this way in the United Kingdom are proven pulmonary embolism occurring despite adequate treatment with anticoagulant drugs, contraindications to treatment with anticoagulant drugs with demonstrable thrombosis in the femoral or iliac veins, complications of treatment with anticoagulant drugs requiring discontinuation of treatment, or proximal thrombosis in the iliac vein or vena cava in patients about to undergo surgery (for example, pelvic reconstruction after trauma).²

While it is true that randomised studies are lacking, it is equally true that it would be difficult ethically to assign patients randomly to treatment given the accepted indications in the United Kingdom. The study shows that filters reduce but do not eliminate the occurrence of pulmonary embolism, which is encouraging, but it did not find a reduction in mortality. This would suggest that filters should not be employed as first line treatment in the population that was

studied; this finding is not surprising. I do not believe, however, that this data should be used to discourage the use of filters to treat those indications described above since the study design did not address those issues.

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1 Minerva. *BMJ* 1998;316:788. (7 March.)

2 Belli A-M, Buckenham T. Vascular intervention: inferior vena cava filters. In: Watkinson A, Adam A, eds. *Interventional radiology: a practical guide*. Oxford: Radcliffe Medical Press, 1996.

Providing letters to patients

Patients find summary letters useful

EDITOR—Essex raises some interesting points about the value of giving patients a written summary of their consultation.¹ The practice of sending patients a letter summarising their consultation is very common in genetic counselling.

A colleague and I have completed a qualitative interview study exploring patients' attitudes about and their use of written summaries of their genetic consultations for hereditary breast and ovarian cancer.² Like Essex, we found that patients responded very positively to these letters. Altogether 37 (93%) out of 40 patients in the sample said that the summary letter aided their understanding or recall of information that had been given in the clinic, or both. The written summary was also perceived as valuable because it could be shown to other clinicians to support the patient's case for gaining access to breast or ovarian screening programmes, it reassured patients that they were taking appropriate action, and it contained information about other relatives' risks. In addition, the written summary was also perceived as a useful tool for disseminating genetic information to other family members; 34 (85%) out of 40 patients said they had used, or intended to use, the written summary of their counselling session to facilitate the communication of genetic information to other biological relatives.

On the basis of our findings we suggest that genetic counsellors send patients a letter summarising their consultations as this may result not only in an increase in the patient's understanding, but may prevent the miscommunication of genetic information within the family. However, we feel that clinicians should be aware that providing patients with a written summary of their consultation may also have negative consequences. It may generate an inappropriate demand for referrals to genetic clinics from family members at low risk, and, more importantly, reading a letter written to the patient may cause needless anxiety among low risk family members.

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1 Essex C. Consultants could give patients a letter summarising their consultation. *BMJ* 1998;316:706. (28 February.)

2 Hallowell N, Merton F. The value of written summaries of genetic consultations. *Patient Education Counselling* (In press.)

GPs can be given copies of letters sent to patients

EDITOR—I would like to reinforce Essex's opinion that consultants should write letters to their patients summarising their findings after a consultation.¹ Since starting the breast screening service in South Essex in 1990, it has been my policy to write to women who have been assessed and whose abnormalities have been found not to require surgical evaluation or treatment.

Initially, I also wrote letters to the woman's general practitioner but I have since found this to be an unnecessary waste of resources. I now write to the woman and send a copy of the letter to her general practitioner. This ensures that the general practitioner knows exactly what the woman has been told and it provides a record of the procedures undertaken and the advice given on future management.

There has been a mixed reception to the letters. One group of general practitioners praised their clarity while another complained about their technical detail. I hope modifications made in response to these comments have made the letters more comprehensible to both the women and their general practitioners.

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1 Essex C. Consultants could give patients a letter summarising their consultation. *BMJ* 1998;316:706. (28 February.)

Summary letters may be especially appropriate after emergency admissions

EDITOR—It is common for professionals such as accountants and solicitors to follow a meeting with a client with a letter recapitulating the points discussed, and Essex is to be congratulated on his initiative in doing the same after paediatric outpatient appointments.¹ Communication is especially impor-

tant at either end of the age spectrum, and some years ago two of the four geriatric teams in our hospital decided to send out letters to patients who had been seen for consultations. The letters were sent after the initial visit and also when results came back or decisions were arrived at which might have made a further letter helpful. Altogether, 79% of 35 patients found the letters "very helpful" and 18% found them "helpful." Questionnaires were also sent to 38 patients in a control group. In this group, 74% indicated that a letter would have been "very helpful" and 23% indicated that it would have been "helpful." We sent separate letters to the patients' general practitioners together with a copy of the letter sent to the patient.

It was a valuable exercise in communication skills, but we had to discontinue the practice due to the need to reduce the secretarial (and medical) workload. Perhaps it would be even more useful to send a similar letter after an emergency admission, since so much of what has happened becomes eclipsed by subsequent events, and memories of procedures and discussions so readily become blurred.

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1 Essex C. Consultants could give patients a letter summarising their consultation. *BMJ* 1998;316:706. (28 February.)

Letters should be used carefully

EDITOR—We were interested to read that Essex advocates giving patients a letter summarising their outpatient consultation.¹ Several authors have already conducted research in this area.^{2,3} We agree that it is of paramount importance that doctors communicate with patients to ensure patient satisfaction and enhance the relationship between doctor and patient. However, if we were to send each patient a letter summarising their consultation the workload that would be generated would be unacceptable both from the medical and secretarial viewpoint, and this procedure is unlikely to be economically viable.

In our work with gastroenterology patients attending outpatient appointments we found that large numbers of patients wanted to receive more information about their condition, its investigation, and its management.⁴ We achieved the same degree of patient satisfaction by providing patients with a copy of the letter that was sent to their general practitioner as when we posted them a separate, tailor made letter.

There are many benefits to patients receiving a copy of the letter sent to their general practitioner: they are able to build their own copy of their medical record, their knowledge increases, and it reminds them of the details of the consultation (as we all know patients may find it difficult to recall details of consultations especially when the subject is emotive).

As patients want more information it becomes our duty to provide it. However, when communicating with patients by sending them copies of letters sent to their general

practitioners the potential for generating anxiety is introduced as some patients will have serious diseases. We advocate sending patients a letter to reinforce what has already been discussed during an outpatient consultation, but believe that doctors should be careful of introducing new information or breaking bad news in a letter as this would be unethical and uncaring.

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1 Essex C. Consultants could give patients a letter summarising their consultation. *BMJ* 1998;316:706. (28 February.)

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4 Eaden JA, Ward B, Smith H, Mayberry JF. Are we telling patients enough? A pilot study to assess patient information needs in a gastroenterology outpatient department. *Eur J Gastroenterology Hepatology* 1998;10:63-7.

Cover picture meant that *BMJ* had descended to level of tabloid newspapers

EDITOR—It was with deep regret that I saw the cover picture for the issue of 6 June. The issues raised by the Bristol case are matters that have grave implications for the whole of the profession.¹ It raised many difficult questions, which the BMA and other professional bodies are seeking to address both in depth and with great urgency.

To sensationalise the issue is unnecessary and deeply offensive to many members of the association. Consultants are only too aware of the great personal tragedy that has affected the families of the children in the Bristol case but nevertheless will be saddened to see a learned journal descend to the level of the tabloid newspapers.

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1 Treasure T. Lessons from the Bristol case. *BMJ* 1998;316:1085-6. (6 June.)

✽The *BMJ* publishes cover pictures to draw attention to the journal publishing a cluster of material on a subject. Our experience is that readers like the occasional use of cover pictures. When we do publish a cover picture we find as strong an image as we can to illustrate the material. Last week's issue contained nine papers that moved on the debate that the Bristol case has started, a debate that may prove to be one of the most important in British medicine this century. We wanted to ensure that readers knew about these articles, and so we decided to publish a cover picture. It was an obvious thing to do to use a strong picture associated with the Bristol case.

Whether or not the cover is tabloid is a matter of opinion; to my mind it simply shows a grieving mother. But nobody could argue that the content, which is what matters most, is tabloid. And the good thing about tabloids is that millions of people read them, whereas the bad thing about many scientific journals is that nobody reads them, not even scientists—*Editor*.

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